Texas Health and Human Services Commission
Vendor Information Form (VIF)

Instructions: This form must be completed and submitted with **each** new contract, amendment, renewal, and/or extension.
(Please type or print information.)

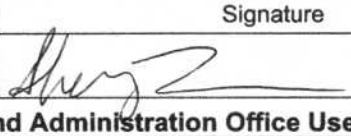
SECTION 1: Contractor's General Information

Legal Contractor's Name:	Women's Health Care Center, Inc		
Legal Doing Business As (DBA) Name:	Women's Health Care Center, Inc		
Physical Address:	2914 S BUCKNER STE B DALLAS TEXAS 75227		
Remit To (Payment) Address:	2914 S BUCKNER STE B DALLAS TEXAS 75227		
Enter Texas Identification Number (TIN)	Texas Identification Number (TIN): -943432832 (11 digit TIN must be provided) **(Contact Accounts Payable at Vendor@hhsc.state.tx.us for valid 11 digit TIN (if unknown)**		
Select the Legal Status:	☐ For-profit Entity	☒ Non-profit Entity	
Select the Business Structure:	☒ Corporation ☐ Joint Venture ☐ Partnership* ☐ Limited (Liability) Company ☐ Limited (Liability) Partnership ☐ Sole Proprietorship ☐ Governmental Entity (must specify): _____ ☐ Other (must specify): _____ * If Partnership, must provide SSN or TIN for minimum of two partners		
	Partner Name: _____	TIN : _____	
	Partner Name: _____	TIN : _____	
If applicable, enter appropriate information:	State of Incorporation: TEXAS	Texas Charter Number: _____	Name of Parent Entity: _____

SECTION 2: Contractor's Contact Information

Person Who Will Sign the Contract		Point of Contact for Contract	
Name:	SHERRY TENISON	Name:	SHERRY TENISON
Title:	EXECUTIVE OFFICE	Title:	EXECUTIVE DIRECTOR
Mailing Address:	2914 S BUCKNER	Mailing Address:	2914 S BUCKNER STE B
Telephone:	214-275-5256	Telephone:	214-275-5256
Fax:	214-275-5284	Fax:	214-275-5284
E-mail:	SHERRYTENISON@YAHOO.COM	E-mail:	SHERRYTENISON@YAHOO.COM

SECTION 3: Contractor's Authorized Signature (or HHSC Contract Manager)

Printed Name	Signature	Date	Phone Number
SHERRY TENISON		8/1/2016	214-703-6527

SECTION 4: ECPS Contract and Administration Office Use Only

Contractor to Receive Payment: ☐ No ☐ Yes	Revised [redacted]
Contract Number:	

FORM I: FAMILY PLANNING PROGRAM CLINIC SITES

Legal Business Name: Women's Health Care Center, INC **Clinic Site # 1_ of 1__**

CLINIC SITE INFORMATION: Complete this form for **EACH** clinic site that will provide Family Planning Program services funded under this enrollment.

Clinic Name:	**Women's Health Care Center, INC**				
Street Address:	**2914 S Buckner**			Suite:	B
City:	**Dallas**	County: **Texas**	Zip Code:	**75227**	HHSR: 3
Clinic APPOINTMENT Phone #:	**214-275-5256**				Revised [redacted]
Clinic PRIMARY Phone #:	**214-275-5256**		Fax:	**214-275-5284**	
Service Area *(counties to be served by this clinic site)*:	**Dallas**				
Contact Person:	Sherry Tenison				
Pharmacy License #:		Class:	Date of Pharmacy License Application Submission: 6-24-16		
TPI#:	156721606		NPI #:	1265462865	
Date of Medicaid Application Submission(if no TPI# or NPI#):					
Subcontractor Site:	☐ Yes	☒ No			
Mobile Site:	☐ Yes	☒ No			

CLINIC HOURS

DAY	HOURS OF OPERATION					
	Morning		Afternoon		Evening (after 5pm)	
	From	To	From	To	From	To
MONDAY	9	1	2	5		
TUESDAY	9	1	2	5		
WEDNESDAY	9	1	2	5		
THURSDAY	9	1	2	5		
FRIDAY	9	1	2	5		
SATURDAY	9	12				
SUNDAY	Closed					

TEXAS MEDICAL BOARD

IDENTIFICATION CARD

LICENSE/PERMIT NUMBER
D9338

EXPIRATION DATE
05/31/2018

BERNARD FRANK ADAMI, MD
2225 PEGGY LN
GARLAND TX 75043-5708

PHYSICIAN FULL PERMIT

TEXAS MEDICAL BOARD

P.O. BOX 2029 • AUSTIN, TEXAS 78768-2029

PHYSICIAN FULL PERMIT

LICENSE/PERMIT NUMBER
D9338

EXPIRATION DATE
05/31/2018

BERNARD FRANK ADAMI, MD
2225 PEGGY LN
GARLAND TX 75043-5708

THIS CERTIFIES THAT THE LICENSEE/PERMIT HOLDER NAMED AND NUMBERED HEREON HAS PROVIDED THIS BOARD THE INFORMATION REQUIRED AND HAS PAID THE FEE FOR REGISTRATION FOR THE PERIOD INDICATED ABOVE
PLEASE KEEP THIS BOARD NOTIFIED OF CHANGE OF ADDRESS

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IDENTIFICATION CARD

LICENSE/PERMIT NUMBER
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PLEASE KEEP THIS BOARD NOTIFIED OF CHANGE OF ADDRESS

FORM A: FACE PAGE

This form requests basic information about the Applicant and project, including the signature of the authorized representative. The face page must be completed in its entirety.

APPLICANT INFORMATION

1) **LEGAL BUSINESS NAME:** WOMEN'S HEALTH CARE CENTER, INC.

2) **MAILING Address Information** (include mailing address, street, city, county, state and zip code):
2914 S BUCKNER STE B DALLAS TEXAS 75227

3) **PAYEE Name and Mailing Address** (if different from above):

4) **DUNS Number** (9-digit): 829195259

5) **Health and Human Service Region:** 3

6) **Federal Tax ID No.** (9 digit), **State of Texas Comptroller Vendor ID No.** (14 digit) or **Social Security Number** (9 digit): 943432832

The Applicant acknowledges, understands and agrees that the Applicant's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.

7) **TYPE OF ENTITY** (check all that apply):

- ☐ City
- ☐ County
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☒ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith Based (Nonprofit Org)
- ☐ Individual
- ☐ Federally Qualified Health Centers
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

If incorporated, provide 10-digit charter number assigned by Secretary of State: 0800987809

8) **BUDGET PERIOD:** **Start Date:** July 1, 2016 **End Date:** August 31, 2017

9) **COUNTIES SERVED BY FAMILY PLANNING PROJECT:** (complete Form C:Texas Counties and Regions) DALLAS

10) **PRIMARY PLACE OF SERVICES PROVIDED** 2914 S BUCKNER STE B DALLAS TEXAS 75227

11) **TOTAL FUNDING REQUESTED:** 300,000 Revised

Fee for Service: $300,000 | Categorical: 0

12) **PROJECTED EXPENDITURES**

Does Applicant's projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for Applicant's current fiscal year (excluding amount requested in line 9 above)? **

Yes No X

***Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.*

13) **FAMILY PLANNING (FP) PRIMARY CONTACT PERSON**
Name: SHERRY TENISON RN, EXECUTIVE DIRECTOR
Phone: 214-275-5256
Fax: 214-275-5284
Email SHERRYTENISON@YAHOO.COM

14) **FINANCIAL OFFICER**
Name:
Donnie
Graham
Phone 214
Fax:214-
275-
5284
Email:Do
nnie
Graham
@

The facts affirmed by me in this proposal are truthful and I warrant the Applicant is in compliance with the assurances and certifications contained in **APPENDIX I: HHSC Assurances and Certifications**. I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the Applicant and I (the person signing below) am authorized to represent the Applicant.

15) AUTHORIZED REPRESENTATIVE

Name: Sherry Tenison RN Executive Director
Title: Executive Director

16) SIGNATURE OF AUTHORIZED REPRESENTATIVE

17) DATE 8/1/2016 Revised

Phone: 214-275-5256
Fax: 214-275-5284
Email: sherrytenison@yahoo.com

8-1-2016

Revised [redacted]